# STATE OF OREGON

# COVER PAGE

Oregon Health Authority

# CARE COORDINATION, INTEGRATION AND EVALUATION SERVICES

Request for Proposal (RFP)

# OHA-4140-16

Date of Issue: January 28, 2016

Closing Date: March 24, 2016

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# SECTION 1: GENERAL INFORMATION

## 1.1 INTRODUCTION

The State of Oregon, acting by and through the Oregon Health Authority ("Agency"), is issuing this Request for Proposals for a statewide program of care coordination, integration, and evaluation services. The program includes disease and intensive care management, a nurse triage and advice line, and independent assessments.

The Work solicited in this RFP applies to clients in the Medicaid fee-for-service ("FFS") population, with or without Medicare and to coordinated care organization ("CCO") enrolled members receiving FFS behavioral health services and FFS home and community based services ("HCBS"). The RFP does not include case/disease management, care coordination and integration services to Oregon Health Plan ("OHP") members enrolled in coordinated care organizations; or participating in the Program for All-Inclusive Care for the Elderly ("PACE"). This exclusion does not preclude or eliminate the Proposer from providing administrative, utilization management, methodology, risk stratification, global member call center services, or other innovative information system services to support the CCO infrastructure throughout Oregon.

This RFP provides an opportunity for vendors to partner as contractor and subcontractor to provide the services and deliverables described in the Scope of Work. Vendors working together, as contractor and subcontractor, shall submit one Proposal under the name of a lead entity and the lead entity shall be listed as the Proposer. The Contract Award would be to the lead entity or Proposer to this RFP.

Proposers to this RFP are expected:

- to have knowledge of the Oregon Health Plan and the coordinated care organization health delivery system and its progressive vision;
- to understand the differences between the Oregon Health Authority and the long term care system of programs from the Department of Human Services Aging and People with Disabilities;
- to know the Oregon statutes, rules, and guidelines applicable to the Oregon Health Plan managed care services;
- to know the federal Centers for Medicare and Medicaid Services ("CMS") requirements for serving individuals who are fee-for-service and fee-for-service dually eligible; and
- to have knowledge of the disparities that exist in the Medicaid population and subpopulations.

The Contract awarded as a result of this RFP must meet CMS's approval and comply with the Oregon State Plan Amendment and waivers. CMS defines the Contract as a pre-paid ambulatory health plan ("PAHP") type of service. Approval of the Contract by CMS will be based on the ability of the awarded Contract to meet PAHP federal requirements. Contractual terms and conditions required by CMS will not be negotiable in the Contract resulting from this RFP.

Additional details on the Scope of the goods or services or both are included in the Scope of Work section.

Agency anticipates the award of one Contract from this RFP. The initial term of the Contract is anticipated to be up to three years with options to renew up to a maximum of five years.

### 1.2 SCHEDULE

The table below represents a tentative schedule of events. All times are listed in Pacific Time. All dates listed are subject to change. N/A denotes that event is not applicable to this RFP.

| Event | Date | Time |
|---|---|---|
| RFP Issued | January 28, 2016 | 3:00 PM |
| Questions / Requests for Clarification Due | February 11, 2016 | 5:00 PM |
| Answers to Questions / Requests for Clarification Issued (approx.) | February 17, 2016 | |
| RFP Protest Period Ends | March 14, 2016 | 3:00 PM |
| Closing (Proposals Due) | March 24, 2016 | 3:00 PM |
| Opening of Proposals | March 24, 2016 | 3:15 PM |
| Presentations, Demonstrations, or Interviews | April 13 – 14, 2016 | |
| Issuance of Notice of Intent to Award (approx.) | April 21, 2016 | |
| Award Protest Period Ends | April 28, 2016 | |

### 1.3 SINGLE POINT OF CONTACT (SPC)

The SPC for this RFP is identified on the Cover Page, along with the SPC's contact information. Proposer shall direct all communications related to any provision of the RFP, whether about the technical requirements of the RFP, contractual requirements, the RFP process, or any other provision only to the SPC.

## SECTION 2: AUTHORITY, OVERVIEW, AND SCOPE

### 2.1 AUTHORITY AND METHOD

Agency is issuing this RFP pursuant to its authority under OAR 125-246-0170(2).

Agency is using the Competitive Sealed Proposals method, pursuant to ORS 279B.060 and OAR 125-247-0260. Agency may use a combination of the methods for Competitive Sealed Proposals, including optional procedures: a) Competitive Range; b) Discussions and Revised Proposals; c) Revised Rounds of Negotiations; d) Negotiations; e) Best and Final Offers; and f) Multistep Sealed Proposals.

## 2.2 DEFINITION OF TERMS

For the purposes of this RFP, capitalized words will refer to the following definitions.

### 2.2.1 General Definitions

Capitalized terms not specifically defined in this document are defined in OAR 125-246-0110.

### 2.2.2 Solicitation Specific Definitions

**2.2.2.1** **DHS-APD** means the State of Oregon, Department of Human Services, Aging and People with Disabilities, its employees and authorized agents.

**2.2.2.2** **Evaluation Committee** means the group of subject matter experts selected by OHA-HSD and DHS-APD that will evaluate the Proposals and will rank them according to the scoring systems described in this RFP. The role of the Evaluation Committee is public and members are accountable for their actions regarding the solicitation and the evaluation process.

**2.2.2.3** **Key Personnel or Key Persons** means the person or persons on Proposer's staff to be assigned to perform the Work under the Contract.

**2.2.2.4** **Office of Contracts and Procurement** or **OC&P** means the entity that is responsible for the procurement process for OHA.

**2.2.2.5** **OHA-HSD** means the State of Oregon, Oregon Health Authority, Health Systems Division, its employees and authorized agents. Medical Assistance Programs ("MAP") and Addictions and Mental Health ("AMH") were merged into the Health Systems Division in 2015.

### 2.2.3 Contract Specific Definitions

Capitalized terms specific to the Scope of Work and the Contract resulting from this RFP are located in Attachment A Sample Contract.

## 2.3 OVERVIEW

### 2.3.1 Agency Overview and Background

#### 2.3.1.1 Oregon Health Authority, Health Systems Division ("OHA-HSD")

The Oregon Health Authority's Health Systems Division.is responsible for administration of state and federal funded medical assistance programs including Title XIX Medicaid and Title XXI State Children's Health Insurance Program ("SCHIP").

The Oregon Health Plan's Prioritized List of Health Services is used to prioritize services and provide care for Oregonians. The Prioritized List of Health Services emphasizes prevention and patient education. Treatments that prevent more complex or life threatening illness are ranked at a higher priority than services that treat less life threatening illnesses. The Prioritized List of Health Services is available on the OHA website:
http://www.oregon.gov/oha/herc/Pages/Prioritized-List-Overview.aspx

Providers enrolled with the Medical Assistance Program provide OHP members covered health services under the Prioritized List of Health Services. Payments to these fee-for-service providers are governed by the MAP General Rules, OAR 410-120-0000 et. Seq., and the applicable, specific, program rules.

Oregon continues to have a fee-for-service as well as an OHA Medicaid-funded long-term care delivery system, in addition to the coordinated care organization delivery system structure of health services.

The Health Systems Division is also responsible for the programs which assist Oregonians to achieve physical, mental, and social wellbeing by providing access to health, mental health, and addiction services and supports to meet the needs of adults and children to live, be educated, work and participate in their communities. OHA-HSD works in partnership with individuals and their families, counties, other state agencies, providers, advocates and communities to accomplish the following goals.

- Improve the lifelong health of all Oregonians;
- Improve the quality of life for the people served;
- Increase the availability, utilization, and quality of community-based, integrated healthcare services;
- Reduce overall healthcare and societal costs through appropriate investments;
- Increase the effectiveness of the integrated healthcare delivery system;
- Increase the involvement of individuals and family members in all aspects of healthcare delivery and planning;
- Increase accountability of the healthcare system; and
- Increase the efficiency and effectiveness of the state administrative infrastructure for healthcare.

#### 2.3.1.2 Department of Human Services, Aging and People with Disabilities ("DHS-APD")

The aging population in Oregon is projected to increase to 1.1 million by the year 2040. People are living longer and actively with disabilities. In 2006 approximately 50,000 Oregonians were living actively with a disability. The number increased to 80,000 by 2012 and includes Medicaid, Supplemental Nutrition Assistance Program ("SNAP"), Medicare Buy-in, Developmental Disability, and Addictions and Mental Health ("AMH") eligible individuals under the age of 65.

DHS's Aging and People with Disabilities is built on a foundation with values that have remained consistent over time (ORS 410):

- Goals: health, honor, dignity, lives of maximum independence.
- Emphasis on choice and independence.
- Support for people with disabilities.
- Based on partnerships and coordination.
- Promote community involvement.
- Advocate for seniors and individuals with disabilities.

### 2.3.2 Project Overview and Background

#### 2.3.2.1 Health System Transformation

Oregon's Health System Transformation represents an evolution of the Oregon Health Plan and coordinated care to focus on preventive and primary care, evidence-based and culturally-specific services, and effective care management. The goals of coordinated care are to move the fragmented care to an organized and seamless delivery system of care.

Coordinated care organizations act as agents of the Health System Transformation designated by HB 3650 (2011) and SB 1580 (2012) and applicable administrative rules. The CCO work is guided by the policy objectives of Health System Transformation to achieve the Triple Aim of Healthcare.

As part of Health Systems Transformation and in relation to the delivery system for Medicaid and long-term services and supports to seniors and people with disabilities, a Memorandum of Understanding ("MOU") was required between CCOs and contracted organizations or the organizations that contracted with DHS. The seven domains addressed in the MOU are:

- Prioritization of high need members.
- Development of individualized care plans.
- Transitional care practices.
- Member engagement and preferences.
- Establishing member care teams.
- Health disparities.
- Independent assessments for home and community based services.

Voluntary domains that are relevant to alignment and coordination are:

- Use of best practices.
- Use of health information technology.
- Member access and provider responsibilities.
- Outcome and quality measures.
- Governance structure.

- Learning collaboratives.
- Role of primary care homes.
- Safeguards for members.

#### 2.3.2.2 Coordinated Care Organizations

Coordinated Care Organizations are providing care to achieve Oregon's Triple Aim of Healthcare: "*Better Health, Better Care, Less Cost."*

Essential elements of Coordinated Care Organizations are:

- Integration and coordination of benefits and services;
- Local accountability for health and resource allocation;
- Standards for safe and effective care, including care that is culturally and linguistically appropriate; and
- A global Medicaid budget tied to a sustainable rate of growth.

The CCO contractor is a community-based organization governed by a partnership among providers of care, socially and culturally diverse community members, and those taking financial risk. The CCO contractor has a single global Medicaid budget that grows at a fixed rate, and is responsible for the integration and coordination of physical, mental, behavioral and dental healthcare for people eligible for Medicaid. The CCO contractor is the single point of accountability for the health quality and equitable outcomes for the Medicaid population it serves. The CCO has the financial flexibility within available resources to achieve the greatest possible outcomes for their membership.

CCO objectives include:

- Ensuring access to an appropriate delivery system network centered on Patient-Centered Primary Care Homes ("PCPCH");
- Ensuring member rights and responsibilities;
- Working to eliminate health disparities among their member populations and communities;
- Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;
- Developing a health information technology infrastructure and participating in health information exchange;
- Ensuring transparency and reporting quality data; and
- Assuring financial solvency.

Oregon's existing Medicaid delivery system consists of:

- 16 Coordinated Care Organizations ("CCOA") offering mental, physical, and dental healthcare;
- 16 Coordinated Care Organizations ("CCOB") offering mental and physical healthcare;

- 12 Coordinated Care Organizations ("CCOE") offering mental healthcare;
- 12 Coordinated Care Organizations ("CCOG") offering mental and dental healthcare;
- 8 Dental Care Organizations ("DCO"), not integrated within a CCO, offering dental healthcare;
- 1 Mental Health Organization ("MHO"), not integrated within a CCO, offering mental healthcare;
- The Providence Elderplace PACE program; and
- The fee-for-service program offering mental, physical, and dental healthcare.

### 2.3.3 Purpose

#### 2.3.3.1 Oregon Health Plan Care Coordination

The purpose of the statewide program of care coordination, healthcare integration, and assessment services will serve Oregon Health Plan Medicaid fee-for-service members with or without Medicare. The program's focus for this population is prevention of illness, disease, and loss of function; ensuring access to healthcare; eliminating healthcare disparities; and ensuring that assessments and evaluations are independent and unbiased.

Of the approximately 1,100,000 current OHP members about 10 % remain FFS Clients. This FFS population of approximately 110,000 is eligible for all aspects of care coordination services including disease and intensive care management and the nurse triage and advice line. At this time Medicaid fee-for-service clients without Medicare number between 80,000 and 85,000, and Medicaid with Medicare (dual eligible) are approximately 31,000.

The fee-for-service population includes:

- Adult individuals with a third-party resource ("TPR");
- Native Americans by choice;
- Dual eligible by choice;
- Individuals in long term care;
- Citizen-Alien Waived Emergency Medical ("CAWEM") Plus;
- Individuals living in areas without CCO capacity or CCO coverage;
- Individuals who opted out of CCO participation or who are excluded from CCO participation;
- CCO enrolled members receiving fee-for-service outpatient and residential behavioral health services;
- CCO enrolled members receiving fee-for-service home and community based services;
- CCO members granted a temporary exemption from CCO enrollment and are choosing out of hospital births ("OOHB");
- Special populations of Medicare recipients requiring higher coordination and integration of care;

- CCO and FFS clients with suspended eligibility who are awaiting discharge from the Oregon State Hospital; and
- Individuals who are FFS Clients and in foster care.

The volume of the fee-for-service population will fluctuate during the Contract and a Proposer must have the ability to evolve with the changing landscape of healthcare while maintaining member focused services.

Excluded from the care coordination program are OHP members:

- Enrolled in a Coordinated Care Organization for physical health (CCOA, CCOB);
- Participating in the Program for All-inclusive Care for the Elderly ("PACE");
- Participating in any other program providing duplicate comprehensive care coordination;
- Residing outside an OHP care coordination contracted area.

OHP FFS members often receive healthcare services through multiple delivery systems that include mental health, senior services, disability services, children's services, private and public providers, and social supports. Agency expects the statewide program for care coordination, healthcare integration, and assessment and evaluation will take a comprehensive, integrated approach to meet the FFS client's needs. Care management under the program should incorporate health services, intrinsic motivation, assessments, interventions, education, plans-of-care, referrals and referral management, ensuring access, monitored progress, and prevention of chronic disease. Care management services should demonstrate progress toward short and long term goals of the member, and improved member self-management skills and positive outcomes.

Proposer's statewide program must be comprehensive, inclusive, and collaborative between all available healthcare services and must be innovatively proactive about early intervention with members identified at high risk for more complex conditions and diseases as well as at risk for utilization of more costly services or at risk due to inadequate access to needed services.

CMS has indicated that the care of the fee-for-service clients is to be managed and coordinated in accordance with the State Plan Amendment and the Affordable Care Act and is to closely align with the State health outcome metrics.

#### 2.3.3.2 1915(i) Home and Community Based Services ("HCBS") Independent and Qualified Agent ("IQA)"

For services provided through authority of the 1915(i) HCBS State Plan Amendment, Agency is responsible for establishing a process to ensure that assessments and evaluations are independent and unbiased. The purpose of this is to ensure that providers are making eligibility and treatment decisions that are in the best interest of the recipient rather than directed at client collection and retention or maintenance of billing activities.

Within the 1915(i) HCBS State Plan Amendment, the Oregon Health Authority has elected to delegate independent evaluation or re-evaluation to an agent that is independent and qualified. The 2016 HCBS standards as described in CFR 441.720 expand the role of the independent agent to include assessment, service planning, and transition management and planning. Agency has elected to expand the role of the independent and qualified agent ("IQA") beginning with the implementation of the Contract resulting from this RFP.

Based upon the standards defined in the Contract resulting from this RFP, Proposer shall perform the duties of the IQA for 1915(i) HCBS services provided to members receiving fee-for-service home based habilitation, home and community based behavioral habilitation, and home and community based psychosocial rehabilitation for individuals with chronic mental illness that are billed under the Medicaid optional 1915 (i) State Plan Home and Community Based Services benefit.

## 2.4 SCOPE OF WORK

Work to be performed under the Contract awarded through this RFP includes:

### 2.4.1 Care Coordination

**2.4.1.1** Provide a comprehensive, seamless, statewide program of care coordination services to Oregon Health Plan FFS members using evidence-based practices and strategies.

**2.4.1.2** Provide care coordination services in accordance with the intent and objectives of the Oregon Health System Transformation. The Health System Transformation websites are: http://www.oregon.gov/oha/Transformation-Center/pages/index.aspx and http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf .

**2.4.1.3** Design and operate a care coordination program in accordance with federal, State, Oregon Health Plan, Oregon Health Authority, and Department of Human Services' statutes, rules, regulations and guidelines.

**2.4.1.4** Have an understanding of available provider networks and pursue engagement with those providers for compliance with the provisions of the Contract. Ensure coordinated healthcare services are provided by the most appropriate level of healthcare provider.

Work will not include contracting with healthcare provider networks and Proposer will not be the payer of medical treatments or procedures rendered to the FFS Client.

**2.4.1.5** Transition the FFS Client through a continuum of coordinated care services using cost-effective methods that meet the FFS Client's needs.

**2.4.1.6** Contact the FFS Client to determine the appropriate care coordination services for goal achievement and improved clinical outcomes. In-person contacts or assessments are arranged based on claims, prior assessments, and need due to health disparity or barriers to healthcare access.

**2.4.1.7** Verify FFS Client's eligibility for services, benefit package, service provider status, and funded service coverage based on the OHP Prioritized List of Health Services and the Medicaid Management Information System ("MMIS").

**2.4.1.8** Perform assessments of FFS Clients. Obtain an understanding of risks, chronic conditions or disease processes. Develop individualized care management action plans, prioritize interventions, and plan care coordination follow-up.

**2.4.1.9** Prepare written plans-of-care for FFS Clients. Address identified areas of risk and include goals established with the FFS Client. Support the ability of the FFS Client to be safely and effectively maintained in the setting of their choice and at the most efficient and effective level of care. Emphasize the FFS Client's ability to remain independent in Client's own residence or in home and community-based services.

**2.4.1.10** Schedule regular follow-up for the FFS Client with appropriate clinical and non-clinical staff based on the FFS Client's specific healthcare needs and as described in the plan of care. Adjust the frequency of the clinical and non-clinical staff support as the FFS Client progresses toward meeting the goals developed in the plan of care. For OHP members receiving fee-for-service behavioral health services, the clinical staff must be a Qualified Mental Health Professional. Provide referrals and follow-ups appropriate for dental health clients. Develop access strategies for FFS Clients' oral health.

**2.4.1.11** Perform level of care and level of service assessments for FFS Clients residing in Agency licensed behavioral health treatment programs. Perform periodic reviews of the assessments while the FFS Client remains in licensed treatment programs, in secure residential programs, or in programs or levels of care that restrict community inclusion.

**2.4.1.12** Provide health literacy assessments to measure the degree to which the FFS Client has the capacity to understand basic health information and services in order to make appropriate healthcare decisions.

**2.4.1.13** Use clinical stratification and risk assessment processes to assign acuity levels for FFS Clients based on clinical, functional, and social needs; patterns of risk for diseases; expected resource requirements; and barriers to accessing healthcare services or any healthcare disparities. Move the FFS Client between clinical stratification and risk assessment levels when indicated by Client's needs.

**2.4.1.14** Review assessments and assessed acuity level, diagnosis, and medical history and update the FFS Client's information and plan of care at subsequent contacts with the FFS Client. Update assessments of behavioral and mental health problems such as depression, substance abuse, and potential for self harm or harm to others.

**2.4.1.15** Provide interventions consistent with evidence-based, clinical guidelines, and recommended treatments for the disease status. Use defined criteria to identify and manage FFS Clients at the most appropriate level of intervention. Ensure the type, frequency, and intensity of interventions are based on the risk and acuity level established for the FFS Client. Ensure interventions are culturally competent and culturally specific. Use interventions and strategies that assist in the elimination of barriers to healthcare and health disparities.

**2.4.1.16** Emphasize the identification, engagement, and improved outcomes of high risk, high acuity FFS Clients. Provide intensive care management coordination to FFS Clients identified as high risk, high acuity.

**2.4.1.17** Track and monitor the FFS Client's progress and clinical outcomes. Identify clinical objectives and goals. Include analysis and representative metrics to demonstrate a baseline from the initial assessment and measure outcomes and performance from subsequent assessments and analysis.

**2.4.1.18** Eliminate barriers to accessing healthcare services with emphasis on adequate access for all individuals served, including transportation, provider network adequacy, and levels of healthcare literacy. Barriers within the State's systems must be disclosed to Agency to seek solutions and removal of the barriers.

**2.4.1.19** Attend treatment team meetings for FFS Clients residing in the Oregon State Hospitals to assist and support the treatment team with discharge planning and community resource identification. Develop a discharge plan that reduces the risk of re-hospitalization and decreases the time a FFS Client waits to access appropriate community services and supports. Arrange the services and supports recommended by the treatment team. Ensure the required eligibility reviews and assessments are completed for community referrals prior to discharge.

**2.4.1.20** Collaborate and coordinate with Agency's Targeted Case Management programs, Patient Centered Primary Care Homes, and with Coordinated Care Organizations to prevent duplication of efforts and assure FFS Clients' continuity of care between delivery systems.

**2.4.1.21** Collaborate and coordinate with the PCPCH care teams to provide interventions, assistance, consultation, transition, and discharge services; to assist with inpatient, outpatient, specialty care, long term services and supports, and emergency department services; and with other care plan activities to promote and support the FFS Client in the PCPCH environment.

**2.4.1.22** Support the use of and refer the FFS Client to chronic disease self-management community-based programs, tobacco cessation services, and appropriate evidence-based prevention screenings and procedures. Ensure referrals are condition, age, and gender appropriate and educational programs and services are culturally and linguistically appropriate.

**2.4.1.23** Focus on effecting the following outcomes:

- Improved FFS Client health and reduced medical costs.
- Improved access to Patient Centered Primary Care Homes.
- Improved access to healthcare services or Targeted Case Management.
- Reduced utilization of hospital emergency departments and hospital re-admissions.
- Reduced progression of chronic conditions and the acuity of catastrophic medical conditions.
- Improved utilization of behavioral health services provided in outpatient and licensed residential and inpatient settings.
- Decreased wait time for individuals waiting to be discharged from the Oregon State Hospital.

### 2.4.2 Disease and Intensive Care Management

**2.4.2.1** Coordinate disease and intensive care management services for FFS Clients with complex physical and mental health needs using integrative and innovative coordinated care practices in a comprehensive delivery system.

**2.4.2.2** Meet the FFS Client's physical, mental, dental, and behavioral health, and long term service and support needs and account for cultural, educational, social, and economic issues that affect the Client's ability to manage their condition, illness, or disease.

**2.4.2.3** Provide the disease and intensive care management services to FFS Clients who are identified as high risk, high acuity through clinical stratification and risk assessment processes.

**2.4.2.4** Provide disease and intensive care management services to FFS Clients identified as having immediate or emergent acute care or transition needs, frequent emergency department utilization or hospitalization, or co-morbidities that require complex medical care or behavioral health management services to assist the FFS Client to cope with their acute condition.

**2.4.2.5** Complete a transition of care assessment, and medication reconciliation when indicated. Work with the Agency's contracted drug utilization review provider to coordinate efforts.

**2.4.2.6** Coordinate disease and intensive care management services with early intervention, waiver, behavioral health, and children and youth services.

**2.4.2.7** Assess the FFS Client's and caregiver's understanding of the key elements of the disease and intensive care management interventions and the approaches to care. Provide options to improve understanding that are culturally and linguistically appropriate.

**2.4.2.8** Connect FFS Clients receiving disease and intensive care management services to physical and mental health services that reduce the chances of catastrophic or severe illness or unnecessary utilization of costlier healthcare or levels of service.

**2.4.2.9** Provide intensive care management services in the FFS Client's home or community as appropriate for the FFS Client.

**2.4.2.10** Coordinate with community healthcare service providers, such as home health, cardiac rehabilitation, physical therapy, psychiatric consultants, community health workers, traditional health workers, and other medically related support services, to assist FFS Clients in the intensive care management program to meet goals set in the individualized plan of care.

**2.4.2.11** Provide face-to-face care coordination or care management interventions to high risk, high acuity FFS Clients in the FFS Client's residence when the intervention does not pose an imminent threat to the safety of the Client or clinical staff, and when it is the most effective and beneficial to the Client.

**2.4.2.12** Follow up and manage the FFS Client's transition from intensive care management to the lower risk, lower acuity healthcare programs for continued support.

**2.4.2.13** Enhance, support, and incorporate into the disease and intensive care management services self-management skills and healthy lifestyles.

**2.4.2.14** Target disparate populations and deploy measures to define paths out of disparity.

**2.4.2.15** Reduce mental, behavioral, oral, and physical health barriers to accessing care from both the FFS Client and service provider perspectives.

**2.4.2.16** Maintain or improve health functioning of recipients of long term services and supports and of long term psychiatric care.

**2.4.2.17** Coordinate with OHA-HSD and DHS-APD and affiliated agencies to increase awareness and utilization of existing intensive care management resources that would be beneficial to FFS Clients.

**2.4.2.18** Focus on the following outcomes:

- Reduced utilization of long term skilled nursing facilities.
- Increased in-home or community residency.
- Improved clinical documentation to support the FFS Client's healthcare setting

- Improved physical, oral, and mental health outcomes as demonstrated by the CCO enrolled populations.

### 2.4.3 Nurse Triage and Advice

**2.4.3.1** Provide nurse triage and advice services by telephone using a toll-free number that is available 24 hours per day, seven days per week to all Oregon Health Plan members.

**2.4.3.2** Ensure personnel who answer nurse triage and advice line calls and manage clinical triage services have the required training, education, and experience to provide the service.

**2.4.3.3** Ensure the nurse triage and advice services do not discriminate between different OHP members and do not vary for those FFS Clients enrolled in specific care coordination programs.

**2.4.3.4** Screen for eligibility for services, insurance plans, and CCO enrollment. Direct FFS Clients to the type of service and level of care required and appropriate for the caller's symptoms or condition under the care coordination and intensive care management programs.

**2.4.3.5** Ensure callers who are enrolled with a CCO, or who can be better served by other OHA or DHS programs, are provided referral information to assist them.

**2.4.3.6** Establish protocols for outreach to callers who are FFS Clients who are eligible for OHP care coordination services and are not enrolled in the program.

**2.4.3.7** Provide telephonic translation or interpreter services and culturally sensitive and linguistically appropriate triage and advice.

**2.4.3.8** Provide educational information as appropriate for telephonic services and make referrals to available sources of healthcare education and instruction.

**2.4.3.9** Contact the local police, fire, and medical rescue agency or 911 to alert authorities when, in the opinion of the triage and advice line staff, there is a suspicion of domestic violence, elder abuse, or other abuse or emergent situations requiring emergency response.

**2.4.3.10** Monitor the nurse triage and advice line services for quality and consistency of services and have process improvement or quality control measures to demonstrate caller satisfaction. Have performance standards and performance measures to track and report performance of the services.

**2.4.3.11** Ensure that callers who are enrolled in the OHP care coordination program are transitioned to and followed by clinical staff resources to manage their healthcare from call to resolution of the issue. Have follow-up procedures for referred or diverted calls. Maintain documentation of the progression to care coordination or intensive care management and the result of referred or transferred calls.

**2.4.3.12** Require subcontractors who are providing nurse triage and advice telephone services to perform the services to the same levels as required under the Contract. Have a plan to monitor the subcontractor's service levels for compliance to the standards and document the compliance.

**2.4.3.13** Prepare and submit performance reports to Agency for the nurse triage and advice line activity and all FFS Client interactions. Include analysis and representative metrics to demonstrate a baseline and measure outcomes and performance from the baseline.

### 2.4.4 Independent and Qualified Agent Services

**2.4.4.1** Perform the duties of an Independent and Qualified Agent ("IQA") for the independent and unbiased review of 1915(i) HCBS services provided to OHP members receiving fee-for-service home based habilitation, home and community based behavioral habilitation, and home and community based psychosocial rehabilitation for individuals with chronic mental illness.

**2.4.4.2** Ensure the Work is performed by an individual whose credentials meet the requirements for a Qualified Mental Health Professional as defined in OAR 410-172-0600.

**2.4.4.3** Provide a Qualified Mental Health Professional, holding a state or national licensure or certification, to review the Work, or participate in the Work, to ensure the performance requirements in this subsection are met.

**2.4.4.4 Eligibility Determination.**

Conduct an evaluation or re-evaluation to determine if a recipient of 1915(i) HCBS services is eligible for the services based on the diagnostic and needs-based criteria defined in Oregon's 1915(i) State Plan Amendment. For purposes of this Work, recipient is an OHP member receiving home or community-based services whether they are FFS Clients, or are enrolled in a CCO and are also receiving FFS services ("Recipient").

**2.4.4.5** Receive requests for eligibility determinations ("Referrals") for individuals who are potentially eligible for 1915(i) HCBS services from a referrer. Provide technical assistance to the referrer about the eligibility determination process.

**2.4.4.6** Develop an electronic database to track the receipt, content, and outcome of the Referral. Electronically archive the Referrals and the clinical documentation accompanying each request. Provide Agency access to the archived documentation.

**2.4.4.7** Develop a website for use by individuals and providers seeking information on making a Referral or getting 1915(i) HCBS services. Include relevant information, links, forms and contact information. Agency has the right to review and approve content of the website and to retain ownership upon expiration or termination of the Contract.

**2.4.4.8** Develop communication materials that describe the Referral, eligibility determination, and independent assessment processes.

**2.4.4.9** Determine whether the Recipient meets the following eligibility requirements:

**a.** Have been diagnosed with a chronic mental illness as defined in ORS 426.495; and

**b.** Have an assessed need consistent with the current or proposed level of care, due to a chronic mental illness.

**2.4.4.10** Assess the Recipient's support needs through a review of the clinical documentation provided by the referrer, including:

**a.** A behavioral health assessment meeting the requirements of OAR 309-019-0135 that has been developed within the last 12 months prior to submission and is signed by a Qualified Mental Health Professional.

**b.** A treatment plan or plan of care, meeting the requirements in OAR 309-019-0140, that has been developed within the last 12 months of the eligibility determination and is signed by a Qualified Mental Health Professional.

**c.** Recent progress notes supporting need for the 1915(i) HCBS services.

**d.** Any additional clinical information supporting medical justification for the 1915(i) HCBS services requested.

**2.4.4.11** Contact the referrer within five business days and schedule an independent assessment for each individual determined eligible for 1915(i) HCBS services.

**2.4.4.12** Complete the eligibility determination review within three business days of receiving the Referral. Complete urgent requests for an eligibility determination within 48 hours of receiving the completed Referral.

**2.4.4.13** Provide written notification of the eligibility determination outcome to the referrer within three business days of a decision. If not eligible, provide an explanation of the decision and information on how to request reconsideration or to appeal the decision. Include instructions on next steps.

**2.4.4.14** Conduct eligibility redeterminations at least every 12 months for each Recipient using the standards defined in the Contract.

**2.4.4.15** Conclude eligibility redeterminations within three business days of any request for redetermination.

**2.4.4.16** Conduct internal quality and process reviews of eligibility determinations to ensure the level of scrutiny is consistent and monitored; including review of the original determination and any redeterminations using new information provided by the Referrer.

**2.4.4.17** Refer requests for appeal of the eligibility determination to Agency. Agency manages the appeal process and notifies the requester of the outcome of the appeal. Agency has the final determination of eligibility under the appeal process described in Oregon Administrative Rule.

**2.4.4.18 Independent Assessments.**

Conduct a face-to-face independent assessment of the needs of a Recipient determined to be eligible for the State Plan HCBS benefits to ensure Recipient's needs are assessed and documented and to establish a plan of care. The independent assessment may include the results of a standardized functional needs assessment.

**2.4.4.19** Conduct and finalize the independent assessment within 14 business days of the eligibility determination.

**2.4.4.20** Ensure the independent assessment meets the following requirements:

**a.** Recipient provides informed consent for the assessment.

**b.** Recipient receives appropriate support during the assessment, including the use of any necessary on-site staff.

**c.** Recipient and, if applicable, the Recipient's authorized representative, are consulted. Opportunity is provided for the Recipient to identify other persons to be consulted, such as the Recipient's spouse, family, guardian, and treating and consulting health and support professionals.

**d.** Examination of the Recipient's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the service plan.

**e.** Examination of the Recipient's physical and mental healthcare and support needs, strengths and preferences, available service and housing options, and a caregiver assessment, when unpaid caregivers will be relied upon to implement the service plan.

**2.4.4.21** Develop a person-centered service plan for the Recipient within three business days of completion of the independent assessment.

**2.4.4.22** Ensure staff conducting the independent assessments are trained in the use of standardized assessment tools selected by Agency. Agency has designated the use of the Level of Care Utilization System (LOCUS) and the Level of Service Inventory (LSI) for residential treatment to fulfill the requirements for independent assessment tools.

**2.4.4.23** Conduct independent assessments every 12 months and, as needed, when the Recipient's support needs or circumstances change significantly, in order to revise the service plan; or as requested by OHA-HSD.

**2.4.4.24 Person-centered Plans of Care.**

Develop a person-centered plan of care jointly with the Recipient, and the Recipient's authorized representative when applicable, based on the independent assessment, to ensure the Recipient receives services, at the level of care and for the period of time, appropriate to the Recipient's assessed need. Development must be timely and must occur at times and locations convenient to the Recipient.

**2.4.4.25** Develop a person-centered plan of care that reflects the services and supports, and the delivery of such services and supports, which are important to the Recipient. Recipient directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Persons chosen by the Recipient are included in the planning.

**2.4.4.26** Provide necessary information in plain language in a manner accessible to individuals with disabilities and persons whose English proficiency is limited. Consider cultural factors.

**2.4.4.27** Prepare the written plan of care commensurate with the Recipient's level of need and the scope of the services and supports available that reflects the Recipient's strengths and preferences and includes individually identified goals and desired outcomes.

**2.4.4.28** Describe any clinical and support needs identified through a functional needs assessment and indicate the paid and unpaid services and supports and the providers responsible for implementation.

**2.4.4.29** Include risk factors and measures to minimize the risk factors, such as individualized backup plans and strategies.

**2.4.4.30** Document and justify any modification that supports a specific and individualized assessed need:

**2.4.4.31** Review the person-centered plan of care, and revise it upon reassessment of functional need, at least every 12 months, or when the Recipient's circumstances or support needs change significantly, or at the request of the Recipient.

**2.4.4.32 Medical Appropriateness Review.**

Conduct reviews to ensure the level of care and the type of service provided to Recipients of 1915(i) HCBS services and secure residential treatments are medically appropriate.

**2.4.4.33** Review services and service requests for compliance with the following rules: OAR 410-172-0710 Personal Care, OAR 410-172-0700 Habilitation, OAR 410-172-0660 Mental Health Rehabilitation, OAR 410-172-0650 prior Authorization, and OAR 410-172-0720 Re-Authorization for Residential Treatment.

**2.4.4.34** Formulate level of care and level of service recommendations for Recipients using the information obtained from the eligibility determinations, independent assessments, and plans of care.

**2.4.4.35** Provide the Agency with a determination approving admission, continued stay, or a recommendation for discharge, for Recipients receiving care within a licensed setting; or approving the type and level of service provided to Recipients of 1915(i) HCBS services.

**2.4.4.36** Communicate the level of care determination and approval to Agency using Agency forms for mental health rehabilitation, community-based habilitation, psychosocial rehabilitation services, personal care and facility-based habilitation services.

**2.4.4.37 Treatment Episode Monitoring.**

Track the length of time between admission and continued stay or discharge within current level of care or current episode of treatment for Recipients in OHA licensed behavioral health residential programs.

**2.4.4.38** Develop a report detailing each Recipient's average length of stay within a licensed residential treatment program. Include data points required by Agency.

### 2.4.5 Outreach and Engagement

**2.4.5.1** Provide outreach activities to engage and enroll FFS Clients in the care coordination program.

**2.4.5.2** Prioritize FFS Clients for engagement and enrollment :

**a.** When the OHP member is determined to be at risk through the daily health stratification and risk assessment process.

**b.** When intervention algorithms, healthcare follow-ups, or health assessments obtained through the nurse triage and advice services indicate the need.

**c.** Through health assessments conducted by care coordination program staff.

**d.** Through healthcare facility or clinic and community-based outreach efforts.

**e.** Using referrals from Agency, providers, and other health entities or agencies, or the FFS Client's family.

**2.4.5.3** Engage by person-to-person contact all new high risk, high acuity and moderate risk, moderate acuity FFS Clients within 30 business days of receipt of the monthly claims information from Agency.

**2.4.5.4** Engage by person-to-person contact all new FFS Clients with lower risk and acuity within 60 business days of receipt of the monthly eligibility report.

**2.4.5.5** FFS Clients are engaged when person-to-person contact is made and the member agrees to receive care coordination services. Document members who have been contacted and who consent to participate in the care coordination program in a member management system. After three unsuccessful contact attempts, mail a contact request.

**2.4.5.6** Develop alternative processes to engage FFS Clients who are difficult to contact by traditional letter carrier services and to report such FFS Clients to Agency for assistance.

**2.4.5.7** Stop attempts to engage a FFS Client:

**a.** Who fails to respond to the telephone and mail contact attempts.

**b.** Whose mail is returned "unable to deliver" with no forwarding information.

**c.** Who does not meet the criteria for an acuity score as determined by the health stratification and risk assessment process.

**d.** Who has opted-out of the care coordination program.

**e.** Who, when contacted, is determined to be not eligible for care coordination.

**2.4.5.8** Attempt to locate and engage FFS Clients in a personal manner in the field, healthcare provider offices, clinic hospitals, or other local resources when the FFS Client remains within the high risk, high acuity level, or at risk for utilization, for greater than 90 calendar days and has failed to respond to attempted contacts or has no active telephone number on file..

**2.4.5.9** Provide care coordination services at any time to FFS Clients who may have opted-out of the program in the past but remain on Medicaid fee-for-service status.

**2.4.5.10** Ensure all communications with FFS Clients:

**a.** Are culturally and linguistically appropriate;

**b.** Are provided in a manner or format easily understood by FFS Client;

**c.** Indicate the toll-free telephone number for OHP care coordination services; and

**d.** Include the care coordination program name and web-site address.

**2.4.5.11** Provide an initiation or initial outreach package to all newly engaged FFS Clients that:

**a.** Includes information about the FFS Client's enrollment in the care coordination program.

**b.** Informs the FFS Client that enrollment is part of the member's Medicaid benefit and that the care coordination program is provided at no cost to member.

**c.** Introduces the care coordination services available to the FFS Client.

**d.** Includes information about care coordination, disease and intensive care management and the nurse triage and advice line.

**e.** Includes a copy of the FFS Client's "Rights and Responsibilities."

**f.** Notifies the FFS Client that participation in the care coordination program is by choice and that the member retains the right to opt out of the program at any time, and may re-enroll at any time without penalty.

**2.4.5.12** Include the following topics in ongoing education and instruction outreach:

**a.** Self-care skills and assistance with securing supportive resources.

**b.** Education and coaching on tobacco cessation and avoidance of second hand smoke.

**c.** Education and assistance on the elimination of barriers to care.

**d.** Education and coaching on the use of medical and community resources, in support of a PCPCH and the FFS Client's health conditions.

**e.** Education and coaching about medication management.

**f.** Health literacy.

**2.4.5.13** Work with healthcare providers, stakeholder groups, OHA-HSD, Oregon State Hospital, and DHS-APD to promote enrollment and participation.

**a.** Establish working relationships, partnerships, or collaborations with, or support the activities of, other OHA divisions, other State agencies, and profit and non-profit organizations as these relate to care coordination and healthcare integration for FFS Clients.

**b.** Incorporate access or referral to, or utilization of, existing resources available from other OHA divisions, State agencies, or profit and non-profit organizations when appropriate to the care coordination and healthcare integration program.

**c.** Institute a Clinical Advisory Committee ("CAC") and establish a charter. Maintain the CAC by meeting twice per calendar year at a minimum but no more often than quarterly. Establish an ongoing positive relationship with the healthcare community and to maintain a consistently high-level of communication with stakeholders. CAC membership shall include, at a minimum, stakeholders approved by Agency, such as but not limited to, a Medicaid recipient, a Native American healthcare leader, a provider representative, an advocacy group representative, a community mental health program representative, and an Agency representative.

**2.4.5.14** Support FFS Client placement in PCPCH and assist Agency in finding Patient Centered Primary Care Homes for FFS Clients. Encourage and promote the benefits of a PCPCH for FFS Clients.

**2.4.5.15** Incorporate the delivery of living well and chronic care model concepts into the care coordination program.

**2.4.5.16** Assist OHA-HSD and DHS-APD in the determination of appropriate care coordination services for activities of daily living, occupational therapy, physical therapy, private duty nursing, medication reconciliation, and post discharge transition of care.

### 2.4.6 Marketing and Communications

**2.4.6.1** Provide quarterly newsletters, mailers, electronic media, enrollment notices and informational, educational and related materials, about important health or wellness topics, using the following guidelines:

**a.** Printed educational materials at the fifth grade reading level.

**b.** Culturally and linguistically appropriate services and programs.

**c.** No cost, 24-hour interpreter or translation services to all non-English speaking persons.

**d.** Alternate formats for the visually impaired that meet or exceed Medicare's section 508 access compliance standards.

**e.** In a manner and format that can easily be understood.

**f.** In prevalent non-English languages.

**g.** Graphic materials reflect demographic makeup of target population.

**2.4.6.2** Collaborate with Agency on the development of new, or revisions to, marketing and communication materials and plans.

**2.4.6.3** Submit all communications, including electronic media, to Agency for review and approval prior to the application of Agency-specific signatures or logos on the communication.

**2.4.6.4** Distribute written materials for FFS Clients within the boundaries of the State of Oregon.

**2.4.6.5** Do not engage in door-to-door, telephone, or any cold-call marketing activities, promotions, or solicitations for any purpose beyond what is specified within the terms of the Contract.

**2.4.6.6** Do not contact FFS Clients at any time for reasons other than those described in the Contract without Agency's prior written approval.

**2.4.6.7** Do not make any assertion or statement, whether written or oral, of an endorsement by CMS, the federal or State government, or any other similar entity, related to the Contract.

**2.4.6.8** Do not make any assertion or statement, whether written or oral, that the FFS Client must enroll in the care coordination program in order to obtain or maintain Oregon Health Plan benefits.

**2.4.6.9** Conduct informational meetings at least quarterly at various locations statewide with the assistance of the CAC. Provide a healthy meal and a travel incentive for participants, and have at least one Agency representative present. Priority must be given to locations that encompass specific disparate populations.

### 2.4.7 Evaluation, Quality Control, Process Improvement

**2.4.7.1** Establish quality control and process improvement programs for the provision of the Work.

**2.4.7.2** Ensure the quality control and process improvement programs are implemented and maintained.

**2.4.7.3** Develop and maintain a quality control and process improvement system to track the management and resolution of FFS Client and healthcare provider complaints, grievances, and compliments.

**2.4.7.4** Monitor and evaluate FFS Client satisfaction.

**2.4.7.5** Identify care coordination service gaps and barriers to care, and implement corrective actions.

**2.4.7.6** Monitor and provide instruction in health literacy to demonstrate improvement in FFS Client's participatory management skills.

**2.4.7.7** Monitor and provide direct supervision and performance management of personnel to ensure the quality of the care coordination and healthcare integration program.

### 2.4.8 Outcome Measurement

**2.4.8.1** Perform critical analysis for evaluation of the care coordination and healthcare integration program.

**a.** Establish baselines for results comparison.

**b.** Monitor the expected clinical outcomes through claims data activity analysis.

**c.** Establish targeted improvement on clinical outcomes.

**d.** Measure the degree of improvement from the baseline to the clinical outcome at the end of each 12 month service cycle.

**2.4.8.2** Develop metrics that are relevant to the evaluation of the care coordination program goals and collect and report specific clinical evaluation and utilization metrics based on those goals.

**2.4.8.3** Align health outcome measurements with the metrics utilized by the CCOs and required by Agency. Evaluate and report the effectiveness and efficiency of care coordination program in meeting the applicable State health outcome metrics. The metrics can be found at http://www.oregon.gov/oha/Pages/metrix.aspx .

**2.4.8.4** Develop and implement a minimum of one quality control or process improvement initiative annually (per calendar year).

### 2.4.9 Data, Records, and Reports

**2.4.9.1** Maintain written or electronic records of all communications (including subcontractor communications) with FFS Clients, such as requests, complaints, and associated clinical outcomes, using a documented records retention policy.

**2.4.9.2** Create and prepare care coordination, disease and intensive care management, nurse triage and advice line and healthcare integration documentation, data and reports. Provide to OHA-HSD and DHS- APD.

**2.4.9.3** Provide OHA-HSD and DHS-APD access to all FFS Client records and data upon request. Provide program financial and operation records for review upon request. Make records available for audit and inspection to assure quality, appropriateness, or timeliness of services and reasonableness of costs.

**2.4.9.4** Prepare and submit all data and documents in a format acceptable to Agency. Revise and resubmit as requested by Agency.

**2.4.9.5** Prepare and submit written status reports to the Contract Administrator at least two times per month.

**2.4.9.6** Prepare and submit formal quarterly and annual reports.

### 2.4.10 Policies and Procedures

**2.4.10.1** Implement and maintain policies and procedures for collecting, maintaining, using, transmitting, sharing, disclosing, storing, and protecting information about FFS Clients and OHP members.

**2.4.10.2** Provide Agency access to review policies and procedures for the care coordination, healthcare integration and independent assessment programs, and records retention.

**2.4.10.3** Audit the care coordination program policies and procedures for compliance with federal, State, Oregon Health Plan, Oregon Health Authority, and Department of Human Services' statutes, rules, regulations and guidelines.

**2.4.10.4** Include a FFS Client "Rights and Responsibilities" in communication policies and procedures and make it available on the internet and in hard copy. The Rights and Responsibilities must include the following provisions:

**a.** The care coordination program shall not discriminate against individuals eligible to enroll in the program on the basis of health status, the need for healthcare services, or sexual orientation.

**b.** The care coordination program shall not discriminate against individuals eligible to enroll in the program on the basis of race, color, gender, religion, or national origin, and must not use any policy or practice that has the effect of discriminating on the basis of race, color, gender, religion, or national origin.

**2.4.10.5** Develop and maintain policies and procedures for the management and resolution of FFS Client and healthcare provider complaints, grievances, and compliments. Complaint and grievance policies and procedures shall not restrict any FFS Client's right to a State fair hearings and appeals process.

### 2.4.11 Personnel

**2.4.11.1** Ensure licensed or certified healthcare professionals or care management coordinators provide ongoing disease management, care coordination, and intensive care management services to FFS Clients.

**2.4.11.2** Ensure professional staff have and maintain the required education, experience, qualifications, licenses, and credentials for healthcare professionals in the positions to which they are assigned under the Contract.

**2.4.11.3** Maintain the operational capacity and staff levels to review complex OHP medical cases by appropriate healthcare staff during normal business hours of 8:00 a.m. to 5:00 p.m., Pacific Time, Monday through Friday, including State of Oregon and federal holidays.

**2.4.11.4** Manage the turnover in staff that has direct contact with FFS Clients and maintain an appropriate case manager-to-FFS Client ratio as member populations fluctuate. Agency recommends a maximum turnover of 25% for staff in the aggregate in a 12 month period and no more than 50% turnover in a functional area.

**2.4.11.5** Ensure telephone or on-site or video language service providers or interpreters are qualified and certified to Oregon standards and comply with OAR 333-002-0000.

### 2.4.12 Key Persons

Key Persons shall include:

**2.4.12.1** Executive Director. The executive director shall be responsible for overall operations and efficiency.

**2.4.12.2** Clinical Operations Manager. The clinical operations manager shall be responsible for the day-to-day operations of the clinical services provided to all FFS Clients and the successful operation of the nurse triage and advice telephonic services. The clinical operations manager must have a doctoral degree in a discipline related to the Work and at least five years' experience.

**2.4.12.3** Medical Director. The medical director shall be responsible for developing and maintaining clinical protocols for FFS Clients, performing case reviews, and working with service providers and stakeholders in support of the OHP care coordination program. The medical director must have at least five years' experience as a medical director for an organization similar in size and scope to the Work under the Contract.

**2.4.12.4** Privacy and Security Officer. The privacy and security officer shall be solely responsible for assuring HIPPA requirements are met and information systems are secure.

**2.4.12.5** Native American Liaison. The Native American liaison shall serve as the sole point of contact for the OHA tribal coordinator and attend all tribal meetings with the OHA tribal coordinator.

**2.4.12.6** Behavioral/Mental Health Assessments Manager. The behavioral and mental health assessments manager shall be accountable for all of the 1915(I) functions and all independent assessments for HCBS Recipients, and similar assessments for other FFS Clients required by OHA or DHS. This position must be a Qualified Mental Health Professional, with a master's degree, and have at least five years' experience with Medicaid populations.

**2.4.12.7** Individuals in the positions of privacy and security officer and Native American liaison may be less than 1.0 FTE or may serve other roles in the organization.

### 2.4.13 Information Systems; Technology

**2.4.13.1** Comply with the information security requirements imposed by Agency if the Work performed requires access to or use of any Agency computer system or information asset.

**2.4.13.2** Complete an Individual User Profile request for each person for whom access is requested if Work requires access to the Agency network or information system.

**2.4.13.3** Maintain privacy and security measures that meet or exceed the standards established by the Contract and in accordance with Agency Privacy and Information Security Incident policies. Provide security risk management plan to Agency when requested.

**2.4.13.4** Provide information systems with the capacity and capability to exchange information or claims data with Agency for the number of FFS Clients in the OHP care coordination program and have the ability to increase capacity and capability as the program increases for the term of the Contract.

**2.4.13.5** Use software applications or other information systems or assets for the selection, referral or direct request, and enrollment of care coordination program FFS Clients. Ensure the proper handling, storage, and disposal of any information assets obtained or reproduced, when the authorized use of that information ends, consistent with the record retention requirements otherwise applicable to the Contract.

**2.4.13.6** Monitor the operation of the care coordination program to include silent monitoring of health coach, triage, disease management, and intensive care management telephone calls and create monthly metrics reports of the triage and advice line activity.

**2.4.13.7** Maintain security of equipment and storage of all information assets accessed through the Contract to prevent inadvertent destruction, disclosure, or loss. Have the capacity and capability to securely accept and transfer data using Secure File Transfer Protocol (SFTP).

**2.4.13.8** Systems must be compatible with the Chronic Disease Payment System and the Medicaid Management Information System and must be able to adapt to changes associated with MMIS during the term of the Contract.

**2.4.13.9** **HIPAA Compliance.** The healthcare component of OHA is a Covered Entity and must comply with the Health Insurance Portability and Accountability Act and the federal regulations implementing the Act (collectively referred to as HIPAA). A Business Associate of the healthcare component of OHA must comply with OAR 943-014-0400 through OAR 943-014-0465 and the Business Associate requirements set forth in 45 CFR 164.502 and 164.504.

**a.** Consult with Agency's Information Security Office when the application of a privacy or security compliance policy may result in a violation of HIPAA requirements.

**b.** Execute an Electronic Data Interchange (EDI) Trading Partner Agreement with Agency and comply with Agency EDI Rules set forth in OAR 943-120-0110 through 943-120-0160.

# SECTION 3: PROCUREMENT REQUIREMENTS AND EVALUATION

## 3.1 MINIMUM REQUIREMENTS

To be considered for evaluation, Proposal must demonstrate how Proposer meets all requirements of this section:

### 3.1.1 Minimum Proposer Requirements

**3.1.1.1** Proposer must be legally qualified to conduct business in Oregon, in accordance with ORS 279B.110. Proposer shall provide its Oregon Secretary of State Business Registry number in its Proposal; or Proposer shall affirm in its Proposal that Proposer will register with the Oregon Secretary of State upon issuance by OC&P of the intent to award a Contract to Proposer. Registration must be completed before Contract will be executed.

**3.1.1.2** Proposer and subcontractor personnel directing care coordination activities should be licensed or certified to provide licensed physical health-related services and mental health services in the State of Oregon. Activities and resources may include or be augmented by personnel outside of Oregon but must be directed by Oregon licensed staff. Documentation confirming the license(s) must be easily identifiable by Agency and the Evaluation Committee.

**3.1.1.3** Proposer must have a minimum of five years' experience in providing coordination of healthcare services for state or federal health and human services programs. Evidence of Proposer's experience must be easily identifiable by Agency and the Evaluation Committee.

**3.1.1.4** Proposer must have a minimum of five years' experience with integration of multiple agency programs and systems, such as Medicaid and Medicare, telephonic triage, disease management, intensive care management, community outreach, and coordination of care. Evidence of Proposer's experience must be easily identifiable by Agency and the Evaluation Committee.

### 3.1.2 Minimum Key Person Requirements

Proposer must employ or contract key person(s) that meet all of the requirements in this section. Proposer may submit one or more key person(s) so long as all requirements are met.

**3.1.2.1** Proposer must have one, full-time equivalent (FTE), medical director position. Evidence of the position and its qualifications must be easily identifiable by Agency and the Evaluation Committee. A position description may be submitted, but Agency reserves the right to approve or deny the medical director if the position is filled after Award of the Contract.

**3.1.2.2** Proposer must have one, FTE, clinical operations manager position to oversee care coordination and integration field staff. This position will be the primary clinical liaison with Agency's clinical reviewers and management staff. Evidence of the position and its qualifications must be easily identifiable by Agency and the Evaluation Committee. A position description may be submitted, but Agency reserves the right to approve or deny the clinical operation manager if the position is filled after Award of the Contract.

**3.1.2.3** Proposer must have one, FTE, behavior and mental health assessments manager position to oversee Work associated with the 1915i HCBS assessments, and other assessments required by Agency, and serve as the liaison between Agency staff and be accountable for that body of Work. Evidence of the position and its qualifications must be easily identifiable by Agency and the Evaluation Committee. A position description may be submitted, but Agency reserves the right to approve or deny the assessments manager if the position is filled after Award of the Contract.

## 3.2 MINIMUM SUBMISSION REQUIREMENTS

### 3.2.1 Proposal Format and Quantity

Proposal should follow the format and reference the sections listed in the Proposal Content Requirements sections. Responses to each section and subsection should be labeled to indicate the item being addressed. Proposal must describe in detail how requirements of this RFP will be met and may provide additional related information.

Proposer shall submit its Proposal without extensive art work, unusual printing or other materials not essential to the utility and clarity of the Proposal. Proposer shall submit both a hard copy on white 8 ½" x 11" Recycled Paper and an electronic copy on electronic media such as thumb drive or CD.

Proposer shall submit an original, bearing the Proposer's authorized representative's Signature, and eight copies of the un-redacted Proposal. In addition, if Proposer believes any of its Proposal is exempt from disclosure under Oregon Public Records Law (ORS 192.410 through 192.505), Proposer shall complete and submit the Affidavit of Trade Secret (Attachment B) and submit a fully redacted version of its Proposal, clearly identified as the redacted version. The redacted version may be submitted on electronic media or in hard copy.

Proposer shall submit its Proposal in a sealed package addressed to the SPC with the Proposer's name and the RFP number clearly visible on the outside of the package.

Proposer's electronic copy of the Proposal, and redacted version if applicable, by USB drive, DVD, or CD must be formatted using Adobe Acrobat (pdf), Microsoft Word (docx), or Microsoft Excel (xlsx).

### 3.2.2 Proposal Page Limit

Proposal is limited to 40 pages. Any pages exceeding this limit may not be provided to the Evaluation Committee or considered in the evaluation. The following items do not count toward the page limit:

- Affidavit of Trade Secret (Attachment B)
- Proposal Certification Sheet (Attachment C),
- Proposer Information Sheet (Attachment D),
- Tax Affidavit (Attachment E),
- Cost Proposal form (Attachment G),
- OMWESB Outreach Plan (Attachment H),
- Resumes,
- Financial statements,
- Reference letters,
- Any required forms, or examples of documentation or reports, and
- Any process maps or workflow diagrams.

### 3.2.3 Authorized Representative

A representative authorized to bind the Proposer shall sign the Proposal. Failure of the authorized representative to sign the Proposal may subject the Proposal to rejection by Agency.

## 3.3 ROUND 1 PROCUREMENT PROCESS

### 3.3.1 Public Notice

The RFP, including all Addenda and attachments, is published in the Oregon Procurement Information Network (ORPIN) at http://www.orpin.oregon.gov. RFP documents will not be mailed to prospective Proposers.

Agency shall advertise all Addenda on ORPIN. Prospective Proposer is solely responsible for checking ORPIN to determine whether or not any Addenda have been issued. Addenda are incorporated into the RFP by this reference.

### 3.3.2 Questions / Requests for Clarification

All inquiries, whether relating to the RFP process, administration, deadline or method of award, or to the intent or technical aspects of the RFP must:

- Be delivered to the SPC via email, facsimile, or hard copy;
- Reference the RFP number;
- Identify Proposer's name and contact information;
- Be sent by an authorized representative;
- Refer to the specific area of the RFP being questioned (i.e., page, section and paragraph number); and

- Be received by the due date and time for Questions / Requests for Clarification identified in the Schedule.

### 3.3.3 Pre-Proposal Conference

A pre-Proposal conference will not be held for this RFP.

### 3.3.4 Solicitation Protests

**3.3.4.1** Protests to RFP

Prospective Proposer may submit a Written protest of anything contained in this RFP, including but not limited to, the RFP process, Specifications, Scope of Work, and the proposed Contract. This is prospective Proposer's only opportunity to protest the provisions of the RFP, except for protests of Addenda or the terms and conditions of the proposed Contract, as provided below.

**3.3.4.2** Protests to Addenda

Prospective Proposer may submit a Written protest of anything contained in the respective Addendum. Protests to Addenda, if issued, must be submitted by the date and time specified in the respective Addendum, or they will not be considered. Protests of matters not added or modified by the respective Addendum will not be considered.

**3.3.4.3** Protests must:

- Be delivered to the SPC via email, facsimile, or hard copy;
- Reference the RFP number;
- Identify prospective Proposer's name and contact information;
- Be sent by an authorized representative;
- State the reason for the protest, including:
    - the grounds that demonstrate how the Procurement Process is contrary to law, Unnecessarily Restrictive, legally flawed, or improperly specifies a brand name; and
    - evidence or documentation that supports the grounds on which the protest is based.
- State the proposed changes to the RFP provisions or other relief sought.

Protests to the RFP must be received by the due date and time identified in the Schedule

Protests to Addenda must be received by the due date identified in the respective Addendum

**3.3.4.4** Protest Response

Agency will respond timely to all protests submitted by the due date and time listed in the Schedule. Protests that are not received timely or do not include the required information may not be considered.

### 3.3.5 Proposal Submission Options

Proposer is solely responsible for ensuring its Proposal is received by the SPC in accordance with the RFP requirements before Closing. Agency is not responsible for any delays in mail or by common carriers or by transmission errors or delays or mistaken delivery. Proposal submitted by any means not authorized will be rejected.

**3.3.5.1** Submission through ORPIN

Submission through ORPIN is not allowed for this RFP.

**3.3.5.2** Submission through Mail or Parcel Carrier

Proposal may be submitted through the mail or via parcel carrier, and must be clearly labeled and submitted in a sealed envelope, package or box. The outside of the sealed submission must clearly identify the Proposer's name and the RFP number. It must be sent to the attention of the SPC at the address listed on the Cover Page.

**3.3.5.3** Submission in Person

Proposal may be hand delivered, and must be clearly labeled and submitted in a sealed envelope, package or box. Proposal will be accepted, prior to Closing, during Agency's normal Monday –Friday business hours of 8:00 am to 5:00 pm Pacific Time, except during State of Oregon holidays and other times when Agency is closed. The outside of the sealed submission must clearly identify the Proposer's name and the RFP number. It must be delivered to the attention of the SPC at the address listed on the Cover Page.

### 3.3.6 Proposal Modification or Withdrawal

Any Proposer who wishes to make modifications to a Proposal already received by Agency shall submit its modification in one of the manners listed in the Proposal Submission Options section and must denote the specific change(s) to the Proposal submission.

If a Proposer wishes to withdraw a submitted Proposal, it shall do so prior to Closing. The Proposer shall submit a Written notice Signed by an authorized representative of its intent to withdraw its Proposal in accordance with OAR 137-047-0440. The notice must include the RFP number and be submitted to the SPC.

### 3.3.7 Proposal Due

Proposal and all required submittal items must be received by the SPC on or before Closing. Proposal received after the Closing will not be accepted. All Proposal modifications or withdrawals must be completed prior to Closing.

Proposals received after Closing are considered LATE and will NOT be accepted for evaluation. Late Proposals will be returned to the respective Proposer or destroyed.

### 3.3.8 Proposal Rejection

Agency may reject a Proposal for any of the following reasons:

- Proposer fails to substantially comply with all prescribed RFP procedures and requirements, including but not limited to the requirement that Proposer's authorized representative sign the Proposal in ink.
- Proposer fails to meet the responsibility requirements of ORS 279B.110.
- Proposer makes any contact regarding this RFP with State representatives such as State employees or officials other than the SPC or those the SPC authorizes, or inappropriate contact with the SPC.
- Proposer attempts to inappropriately influence a member of the Evaluation Committee.
- Proposal is conditioned on Agency's acceptance of any other terms and conditions or rights to negotiate any alternative terms and conditions that are not reasonably related to those expressly authorized for negotiation in the RFP or Addenda.

### 3.3.9 Opening of Proposal

A public Opening will be held on the date and time listed in the Schedule and at the location, stated on the Cover Page. Only the name of the Proposer will be read at the Opening, no other information will be made available at that time. Proposals received will not be available for inspection until after the evaluation process has been completed and the Notice of Intent to Award is issued pursuant to OAR 137-047-0630.

## 3.4 ROUND 1 PROPOSAL CONTENT REQUIREMENTS

Proposal must address each of the items listed in this section and all other requirements set forth in this RFP. Proposer shall describe the Goods to be provided or the Services to be performed or both. A Proposal that merely offers to provide the goods or services as stated in this RFP will be considered non-Responsive to this RFP and will not be considered further.

### 3.4.1 Proposal Certification Sheet

The Proposer shall complete and submit the Proposal Certification Sheet (Attachment C).

### 3.4.2 Proposer Information Sheet

The Proposer shall complete and submit the Proposer Information Sheet (Attachment D).

### 3.4.3 Management Capacity and Capability

Specify the Key Persons to be assigned to the Work. Submit a current resume (not to exceed two pages each) for each Key Person specified by Proposer that demonstrates the qualifications, experience, skills and education for the Work described. For Key Persons not identified prior to Proposal submission, a detailed position description must be submitted with an explanation of how the Key Person position will be filled.

Provide a brief description that illustrates how the Key Persons assigned to the Work will coordinate and accomplish the major program tasks in the Scope of Work. Describe how the Key Persons will contribute to a successful transition and implementation.

### 3.4.4 Transition and Implementation Plan

**A transition and implementation plan must be submitted by all Proposers.**

Provide a plan for the transition to and implementation of Proposer's Services. Describe required resources for the transition and implementation, including Agency resources. Discuss Proposer's procedure for the secure transfer of FFS Client's personal information. Provide a timeline for the activities necessary to implement the Proposer's services with specific tasks and timeframes for completion.

### 3.4.5 Operational Plan

Provide a summary description of Proposer's operational plan to accomplish the major activities or key tasks in the Scope of Work. Provide an overview of its operation of the care coordination, healthcare integration, nurse triage and advice line, and independent agency programs. Briefly describe Proposer's resources and systems. Provide process maps or workflow diagrams to illustrate Proposer's operational plan. If applicable, describe how Proposer will use subcontractors and the services the subcontractors will provide.

### 3.4.6 Financial Condition

Briefly describe Proposer's experience with, and current strategies for, ensuring that the Proposer conducts business in a fiscally responsible manner and remains financially solvent through the proposed Contract period. Describe the Proposer's financial capacity to begin and continue the Scope of Work. Identify the staff or board members that have fiscal responsibilities. Any Proposer that has generated financial statements shall submit copies for the most recent period. If financial statements have not been generated, then Proposer may submit an audit or fiscal review by a certified public accountant, or if the Proposer is a "new" business, include a copy of a business plan completed within the last year.

### 3.4.7 References

Provide at least three letters of reference from current or former client firms for similar projects performed for public entity clients within the last five years. References must verify the quality of previous, related Work and be supportive of Proposer's ability to comply with the Scope of Work. The reference letter should indicate why the reference would continue to do business with the Proposer, if the opportunity were available to the reference. The letters of reference must be included in the Round 1 Proposal.

Agency may check to determine if the provided references support Proposer's ability to comply with the requirements of this RFP. Agency may use references to obtain additional information, break tie scores, or verify any information needed. Agency may contact any reference (submitted or not) to verify Proposer's qualifications.

### 3.4.8 Information Systems

Briefly describe Proposer's information security system and its security risk management plan. Describe Proposer's policies and procedures for privacy and security of FFS Client information. Briefly describe Proposer's system for the analysis of paid claims and eligibility data.

### 3.4.9 Nurse Triage and Advice Telephone Services

Provide a description of Proposer's nurse triage and advice telephone services. Include its purpose, objectives, and goals and a description of the positions assigned. Provide examples of Proposer's forms, documents, or reports.

### 3.4.10 Care Coordination Services

Provide a description of Proposer's care coordination and case management services. Include its purpose, objectives, and goals and a description of the positions assigned. Provide examples of Proposer's documentation and other resources used in providing care coordination services.

### 3.4.11 Independent and Qualified Agent (IQA) Services

Provide a description of Proposer's independent and qualified agent services. Describe Proposer's plan for eligibility determinations, independent assessments, developing plans of care, and conducting medical appropriate reviews for Recipients of 1915(i) HCBS services. Provide an example of the proposed website for the 1915(i) HCBS services.

### 3.4.12 Reports and Documentation

Provide a brief description of the reports and documentation Proposer would use to complete the Work. Include reports or documentation frequency, interpretation, utilization, and distribution. Provide examples of Proposer's reports for tracking, monitoring, and documenting the Work.

### 3.4.13 Evaluation and Health Outcome Measures

Describe Proposer's use of evidence-based practices, interventions, and strategies that objectively show improved health outcomes, reduced medical or healthcare costs, increased ability for the clients to remain independent, and reductions in the progression of chronic conditions and acuity of catastrophic medical events.

### 3.4.14 Quality Control and Process Improvement

Describe Proposer's quality control and process improvement program. Describe how the quality control and process improvement information would be shared with OHA-HSD and DHS-APD. Provide an example of a process improvement project conducted within the last 12 months on a less than optimal performance outcome. Describe how the less than optimal performance was discovered and how it was resolved. Provide examples of actual client or client-member complaints or grievances with personal information unidentified and Proposer's responses and resolutions.

### 3.4.15 Cost Proposal

Proposer must submit a proposal, substantially in the form of Attachment G, for each of the categories listed below based on the Scope of Work. As applicable to each category, proposed cost must include personnel or labor, direct non-labor costs related to the Work, and indirect or overhead charges.

For personnel, the proposal must list the titles of the positions that will perform the Work and the salary or wage including fringe, or the fully loaded rate, for each position.

Reimbursements for in state and out of state travel are not authorized as a separate expense for purposes of the Cost Proposal.

Costs for Work provided by subcontractors must be included.

Each category will be evaluated and scored separately as described in subsection 3.5.2 Evaluation Criteria.

#### 3.4.15.1 Attachment G Part 1 - Nurse Triage and Advice Telephone Services

Submit a monthly rate for the provision of the nurse triage and advice telephone services. Calculate the monthly rate using average utilization and call volume standards, or industry statistical standards, for 110,000 potential users of the services. Provide a description of Proposer's calculation method and any additional information that supports Proposer's method of calculation.

#### 3.4.15.2 Attachment G Part 2 - Care Coordination and Case Management

Submit a per member per month ("pmpm") rate to provide the care coordination and case management, including disease and intensive care management, services. Calculate the pmpm rate using the approximate 110,000 FFS Clients described in subsection 2.3.3.1. Provide a description of Proposer's calculation method and any additional information that supports Proposer's method of calculation.

#### 3.4.15.3 Attachment G Part 3 - Independent and Qualified Agent Services

Submit hourly rates for performing the duties of the IQA for 1915(i) home and community based services. Calculate the hourly rates based on providing the services to one Recipient from a client population of 2200. Include time estimates for completing each of the tasks below. Provide a separate hourly rate for:

- the eligibility determinations,
- the independent assessments,
- the development of the plans of care,
- the medical appropriateness reviews, and
- the treatment episode monitoring.

Provide a description of Proposer's calculation method and any additional information that supports Proposer's method of calculation for each task.

#### 3.4.15.4 Attachment G Part 4 - Performance-based Payments

Provide a description of at least one performance-based payment strategy for each of the following categories: nurse triage and advice telephone services, care coordination and case management services; and independent and qualified agent services. Provide specific details on data collection, metrics, benchmarks, performance measures, outputs and outcomes for the strategies. Describe Proposer's method of determining the payment amount and how or when it would be paid. Include any consequences for poor performance or not achieving the outcomes.

### 3.4.16 Public Record/Confidential or Proprietary Information

All Proposals are public record and are subject to public inspection after Agency issues the Notice of the Intent to Award. If a Proposer believes that any portion of its Proposal contains any information that is a trade secret under ORS Chapter 192.501(2) or otherwise is exempt from disclosure under the Oregon Public Records Law (ORS 192.410 through 192.505), Proposer shall complete and submit the Affidavit of Trade Secret (Attachment B) and a fully redacted version of its Proposal.

Proposer is cautioned that cost information generally is not considered a trade secret under Oregon Public Records Law (ORS 192.410 through 192.505) and identifying the Proposal, in whole, as exempt from disclosure is not acceptable. Agency advises each Proposer to consult with its own legal counsel regarding disclosure issues.

If Proposer fails to identify the portions of the Proposal that Proposer claims are exempt from disclosure, Proposer has waived any future claim of non-disclosure of that information.

## 3.5 ROUND 1 EVALUATION PROCESS

### 3.5.1 Responsiveness and Responsibility Determination

Proposals received prior to Closing will be reviewed for Responsiveness to all RFP requirements including compliance with Minimum Requirements section and Proposal Content Requirements section. If the Proposal is unclear, the SPC may request clarification from Proposer. However, clarifications may not be used to rehabilitate a non-Responsive Proposal. If the SPC finds the Proposal non-Responsive, the Proposal may be rejected, however, Agency may waive mistakes in accordance with OAR 125-247-0470.

In accordance with OAR 137-047-0261(6)(a)(A), Agency may establish a Competitive Range of all Proposers who have made a good faith effort in submitting a Proposal in response to this RFP for the purpose of correcting deficiencies in Proposals for determining responsiveness during Round 1.

At any time prior to award, Agency may reject a Proposer found to be not Responsible.

### 3.5.2 Evaluation Criteria

Proposals determined to be Responsive will be evaluated by an Evaluation Committee. Each Evaluator will evaluate the Proposals and assign points, based on a scale of 0 to 10, to each response to the evaluation criterion listed in this section. An explanation of the values for the 0 to 10 scale is provided below.

SPC may request further clarification to assist the Evaluation Committee in gaining additional understanding of Proposals. A response to a clarification request must be to clarify or explain portions of the already submitted Proposal and may not contain new information not included in the original Proposal.

| POINTS | EXPLANATION |
|---|---|
| 10 | OUTSTANDING - Response meets all the requirements and has demonstrated in a clear and concise manner a thorough knowledge and understanding of the subject matter and project. The Proposer provides insight into its expertise, knowledge, and understanding of the subject matter. |
| 6 – 9 | VERY GOOD – Response provides useful information, while showing experience and knowledge within the category. Response demonstrates above average knowledge and ability with no apparent deficiencies noted. |
| 5 | ADEQUATE – Response meets all requirements in an adequate manner. Response demonstrates an ability to comply with guidelines, parameters, and requirements with no additional information put forth by the Proposer. |
| 1 – 4 | FAIR – Proposer meets minimum requirements, but does not demonstrate sufficient knowledge of the subject matter. |
| 0 | RESPONSE OF NO VALUE – An unacceptable response that does not meet the requirements set forth in the RFP. Proposer has not demonstrated knowledge of the subject matter. |

The total points for each evaluation criterion will then be multiplied by a weight for the criterion to calculate the Round 1 total score for a Proposer by Evaluator. Evaluation criterion weights are provided below. The total scores from each Evaluator will be added together for the Proposer's Round 1 final score.

| Round 1 Evaluation Criteria | Weight |
|---|---|
| 3.5.2.1 Management Capacity and Capability | 10 |
| 3.5.2.2 Transition and Implementation Plan | 10 |
| 3.5.2.3 Operational Plan | 20 |
| 3.5.2.4 Financial Condition | 10 |
| 3.5.2.5 References | 5 |
| 3.5.2.6 Information Systems | 10 |
| 3.5.2.7 Nurse Triage and Advice Telephone Services | 25 |
| 3.5.2.8 Care Coordination Services | 25 |
| 3.5.2.9 Independent and Qualified Agent Services | 25 |
| 3.5.2.10 Reports and Documentation | 15 |
| 3.5.2.11 Evaluation and Health Outcome Measures | 20 |
| 3.5.2.12 Quality Control and Process Improvement | 15 |
| 3.5.2.13 Cost Proposal | 10 |

### 3.5.2.1 Management Capacity and Capability

- How well do the Key Person resumes or position descriptions demonstrate the qualifications, experience, skills, and education required for the Work?
- How well did Proposer describe its use of Key Persons to accomplish the Work and their contribution to a successful transition and implementation?

### 3.5.2.2 Transition and Implementation Plan

- How well does Proposer's transition and implementation plan and timeline meet the needs of the Agency?
- How well does Proposer use its resources for the implementation?
- How realistic is Proposer's timeline and how well does the plan fit the Agency's needs?

### 3.5.2.3 Operational Plan

- How well does Proposer's operational plan summarize the activities or tasks required to accomplish the Scope of Work?
- How well does Proposer's summary address the provision of care coordination, healthcare integration, nurse triage and advice line, and independent agency services?
- How well does Proposer use resources, including subcontractors, and systems to accomplish the Work?

#### 3.5.2.4 Financial Condition

- How well has Proposer described its financial condition?
- How well does the description provide confidence in Proposer's fiscal responsibility and financial solvency?

#### 3.5.2.5 References

- How well do the letters of reference support the Proposer and its ability to comply with the Scope of Work?
- How governmentally diverse are the public entities and how well do they compare with Agency's project?

#### 3.5.2.6 Information Systems

- How well does Proposer's technology and its policies and procedures provide for the privacy and security of confidential information?
- How well does Proposer's system meet the Scope of Work requirement of paid claims analysis and eligibility data?

#### 3.5.2.7 Nurse Triage and Advice Telephone Services

- How well do Proposer's telephonic triage and advice services meet the needs of the Agency?
- How well do Proposer's goals and objectives for the telephonic services align with those of Agency?
- How well-matched are Proposer's positions to the needs of the FFS Clients?

#### 3.5.2.8 Care Coordination Services

- How well does Proposer describe its care coordination and case management services?
- How well do Proposer's goals and objectives for the care coordination services align with those of Agency?
- How well matched are Proposer's positions to the needs of the FFS Client?

#### 3.5.2.9 Independent and Qualified Agent Services

- How well does Proposer describe its independent and qualified agency services?
- How well does Proposer's plan for providing the services meet the needs of the Agency?
- How well does Proposer's description demonstrate its understanding of the requirements of the Work?

#### 3.5.2.10 Reports and Documentation

- How well do the reports and documentation meet the needs of the Agency?
- How well does Proposer demonstrate the reporting and documentation possibilities required by the Scope of Work?

#### 3.5.2.11 Evaluation and Health Outcome Measures

- How well does Proposer describe its approach to meeting the performance outcomes? Would Proposer's approach meet Agency's expectations of performance?
- How well does Proposer use the evidence-based practices, interventions, and strategies to meet the needs of the FFS Client?
- How well does Proposer meet the Agency's goals for improved health outcomes and reduced healthcare costs?

#### 3.5.2.12 Quality Control and Process Improvement

- How well does the quality control and process improvement program support the Agency and its FFS Clients?
- How well does the Proposer's program ensure optimal performance?

#### 3.5.2.13 Cost Proposal

Evaluators will award points, on a scale of 0 to 10, to each Part of Attachment G. The points for each Part will then be combined and that total will be multiplied by the weight to determine the score for the Cost Proposal.

- **Attachment G Part 1 - Nurse Triage and Advice Telephone Services**

  How well does Proposer describe its calculation method for the monthly rate? How well does it demonstrate Proposer's understanding of the scope of the nurse triage and advice telephone services? Is the rate cost effective and within the expected scope of the project budget?
- **Attachment G Part 2 - Care Coordination and Case Management**

  How well does Proposer describe its calculation method for the monthly rate? How well does it demonstrate Proposer's understanding of the scope of the care coordination and case management services? Is the rate cost effective and within the expected scope of the project budget?
- **Attachment G Part 3 - Independent and Qualified Agent Services**

  How well does the Proposer describe its calculation methods for each of the hourly rates? How well does it demonstrate Proposer's understanding of the scope of the independent and qualified agent services? Are the rates cost effective and within the expected scope of the project budget?

- **Attachment G Part 4 - Performance-based Payments**

  How well does Proposer describe its performance-based payment strategies for each of the three categories? How well do the payment amounts and schedule, meet the needs of the Agency? Are the Proposer's strategies measurable and attainable?

## 3.6 ROUND 1 NEXT STEP DETERMINATION

Agency may determine Apparent Successful Proposer at the conclusion of Round 1 evaluation, or Agency may conduct additional rounds of competition if in the best interest of the State. Additional rounds of competition may consist of, but will not be limited to:

- Establishing a Competitive Range
- Presentations/Demonstrations/Additional Submittal Items
- Interviews
- Best and Final Offers

## 3.7 ROUND 1 COMPETITIVE RANGE

### 3.7.1 Competitive Range Determination

Proposers with the three highest scoring Round 1 Proposals will advance to Round 2. Agency may increase or decrease the number of Proposers advancing to Round 2 if there is a natural break in the scores. Agency will post a notice in ORPIN of the Competitive Range Determination for Round 1, which includes the Proposers advancing to Round 2.

### 3.7.2 Competitive Range Protest

Proposers excluded from Round 2 may submit a Written protest of Competitive Range. Protests must:

- Be emailed to the SPC;
- Reference the RFP number;
- Identify Proposer's name and contact information;
- Be sent by an authorized representative;
- State the reason for the protest; and
- Be received by the due date and time identified in the Notice of Competitive Range.

Agency will address all protests within a reasonable time and will issue a Written decision to the respective Proposer. Protests that do not include the required information may not be considered by Agency.

## 3.8 ROUND 2 PROCUREMENT PROCESS

### 3.8.1 Presentations and Interviews

Proposers progressing to Round 2 will be invited to participate in Proposer presentations and interviews. Each Proposer will have an equal opportunity to demonstrate Proposer's capabilities and why it should be awarded the Contract. The presentations and interviews

will be at a location determined by Agency; however, Agency may elect to conduct interviews via teleconference or video conference. Further details about location, dates and times and the presentation and interview process will be included with Notice of Competitive Range.

Proposers must provide all materials and equipment needed. Proposers will not be reimbursed for any costs associated with preparing for or appearing for the presentations and interviews.

#### 3.8.1.1 Presentation

Proposer shall provide a multi-media presentation describing how Proposer will achieve its Proposal objectives and how Proposer sees the Work interconnecting. Proposer shall also describe how its performance-based payment strategies will assist Agency in achieving its goals. Presentations will be limited to 30 minutes for each Proposer.

#### 3.8.1.2 Interview

Proposer shall respond to questions randomly from the Evaluation Committee. The Evaluation Committee may seek more information on any point from the Round 2 presentations or the Round 1 Proposals. Questions or discussion points will not be provided in advance. Interviews will be limited to 30 minutes for each Proposer.

#### 3.8.1.3 Final Comments/Summary

Proposers will have 10 minutes for final comments and to summarize their Proposals.

## 3.9 ROUND 2 EVALUATION PROCESS

### 3.9.1 Responsiveness Determination

Proposers agreeing to participate in Round 2 will be evaluated by an Evaluation Committee as described below. Proposer's presentation and interview will be evaluated for completeness and compliance with Round 2 Evaluation Criteria. Proposer may be asked to provide clarification or to explain portions of the presentation or interview to gain understanding.

### 3.9.2 Evaluation Criteria

Round 2 Proposers will be independently evaluated by the members of the Evaluation Committee. Each Evaluator will evaluate the Proposer's presentation and interview and will assign points, based on a scale of 0 to 10, to each evaluation criterion. An explanation of the values for the 0 to 10 scale is provided below.

| POINTS | EXPLANATION |
|---|---|
| 10 | OUTSTANDING - Response meets all the requirements and has demonstrated in a clear and concise manner a thorough knowledge and understanding of the subject matter and project. The Proposer provides insight into its expertise, knowledge, and understanding of the subject matter. |
| 6 – 9 | VERY GOOD – Response provides useful information, while showing experience and knowledge within the category. Response demonstrates above average knowledge and ability with no apparent deficiencies noted. |
| 5 | ADEQUATE – Response meets all requirements in an adequate manner. Response demonstrates an ability to comply with guidelines, parameters, and requirements with no additional information put forth by the Proposer. |
| 1 – 4 | FAIR – Proposer meets minimum requirements, but does not demonstrate sufficient knowledge of the subject matter. |
| 0 | RESPONSE OF NO VALUE – An unacceptable response that does not meet the requirements set forth in the RFP. Proposer has not demonstrated knowledge of the subject matter. |

**3.9.2.1** Presentation Evaluation

- How well does Proposer describe how Proposer will do the Work? How well does Proposer describe its ability to adapt to the changing healthcare environment?
- How well does Proposer understand the requirements of the coordination of the different elements of the Work?
- How well does Proposer describe its innovations for integration, coordination, and reduction of health disparities?
- How well does Proposer describe its method for completing the assessments within the timeframes required by the Agency?
- How well does Proposer describe its plan for achievement of Oregon's Triple Aim of Healthcare?
- How well does Proposer demonstrate its value to the Agency? How well does Proposer articulate its return on the Agency's investment in the Proposer?

**3.9.2.2** Interview Evaluation

- How well does Proposer respond to the Evaluation Committee's questions?
- Are Proposer's answers feasible and based on fact?

**3.9.2.3** Final Comments/Summary Evaluation

- How well does Proposer articulate its culture and how well does it align with the Scope of Work? How well does Proposer explain why they are the best choice for Agency?

## 3.10 ROUND 2 NEXT STEP DETERMINATION

Agency may determine Apparent Successful Proposer at the conclusion of Round 2 evaluation, or Agency may conduct additional rounds of evaluation if in the best interest of the State. Additional rounds of evaluation may consist of, but will not be limited to:

- Establishing a Competitive Range
- Presentations/Demonstrations/Additional Submittal Items
- Interviews
- Best and Final Offer

## 3.11 COST EVALUATION

The Cost Proposal with the lowest cost will not necessarily be selected. Agency reserves the right to make this determination in the best interest of the State and in accordance with Oregon Administrative Rules.

## 3.12 PREFERENCES

### 3.12.1 Reciprocal Preference

For evaluation purposes per OAR 125-246-0310, Agency shall add a percent increase to each out-of-state Proposer's Proposal price that is equal to the percent preference, if any, given to a Resident Offeror of the Proposer's state.

## 3.13 POINT AND SCORE CALCULATIONS

### 3.13.1 Round 1

Points are the values 0 through 10 assigned by each Evaluator based on the scale provided in the Evaluation Criteria. The point scale values are the same for Round 1 and Round 2.

Scores are the total possible for each criterion as listed in the Round 1 Possible Scores table below. Weights indicate the importance of a criterion to the Agency.

The total points for each evaluation criterion will be multiplied by the weight for the criterion to calculate the Round 1 total score for a Proposer by Evaluator. The Round 1 total scores from each Evaluator will be added together for the Proposer's Round 1 final score.

EXAMPLE: Proposer A receives a Round 1 total score of 1800 from Evaluator #1, 1000 from Evaluator #2, and 600 from Evaluator #3. Proposer A's final score for Round 1 is 3400.

Cost Proposal scores are calculated the same as the other Round 1 Evaluation Criteria.

Round 1 total possible scores are as follows:

| ROUND 1 POSSIBLE SCORES | | Maximum Points | Weight | Max Score |
|---|---|---|---|---|
| 3.5.2.1 | Management Capacity and Capability | 10 | 10 | 100 |
| 3.5.2.2 | Transition and Implementation Plan | 10 | 10 | 100 |
| 3.5.2.3 | Operational Plan | 10 | 20 | 200 |
| 3.5.2.4 | Financial Condition | 10 | 10 | 100 |
| 3.5.2.5 | References | 10 | 5 | 50 |
| 3.5.2.6 | Information Systems | 10 | 10 | 100 |
| 3.5.2.7 | Nurse Triage and Advice Telephone Services | 10 | 25 | 250 |
| 3.5.2.8 | Care Coordination Services | 10 | 25 | 250 |
| 3.5.2.9 | Independent and Qualified Agent Services | 10 | 25 | 250 |
| 3.5.2.10 | Reports and Documentation | 10 | 15 | 150 |
| 3.5.2.11 | Evaluation and Health Outcome Measures | 10 | 20 | 200 |
| 3.5.2.12 | Quality Control and Process Improvement | 10 | 15 | 150 |
| 3.5.2.13 | Cost Proposal | 40 | 10 | 400 |
| | **Round 1 Maximum Total Score (per Evaluator)** | | | 2300 |

### 3.13.2 Round 2

Points are the values 0 through 10 assigned by each Evaluator based on the scale provided in the Evaluation Criteria. The point scale values are the same for Round 1 and Round 2.

Scores are the total possible for each criterion as listed in the Round 2 Possible Scores table below. Weights indicate the importance of a criterion to the Agency.

The total points for each Round 2 evaluation criterion will be multiplied by the weight for the criterion to calculate the Round 2 total score for a Proposer by Evaluator. The Round 2 total scores from each Evaluator will be added together for the Proposer's Round 2 final score.

EXAMPLE: Proposer A receives a Round 2 total score of 500 from Evaluator #1, 250 from Evaluator #2, and 100 from Evaluator #3. Proposer A's final score for Round 2 is 850.

Round 2 total possible scores are as follows:

| ROUND 2 POSSIBLE SCORES | | Maximum Points | Weight | Max Score |
|---|---|---|---|---|
| 3.9.2.1 | Presentation | 10 | 15 | 150 |
| 3.9.2.2 | Interview | 10 | 25 | 250 |
| 3.9.2.3 | Final Comments/Summary | 10 | 10 | 100 |
| | | | | |
| | **Round 2 Maximum Total Score (per Evaluator)** | | | 500 |

### 3.14 RANKING OF PROPOSERS

SPC will rank all Proposers advancing through all rounds of evaluation and will total the final scores from all rounds of competition. Proposer's Round 1 total score will be added to Proposer's Round 2 total score for a final score for the Proposer for the RFP. The RFP final score will be used by the SPC to rank the Proposers. After each applicable preference has been applied, SPC will determine rank order for each respective Proposal and Proposer, with the highest score receiving the highest rank, and successive rank order determined by the next highest score.

# SECTION 4: AWARD AND NEGOTIATION

## 4.1 AWARD NOTIFICATION PROCESS

### 4.1.1 Award Consideration

Agency, if it awards a Contract, shall award a Contract to the highest ranking Responsible Proposer(s) based upon the scoring methodology and process described in Section 3. Agency may award less than the full Scope defined in this RFP.

### 4.1.2 Intent to Award Notice

Agency will notify all Proposers in Writing that Agency intends to award a Contract to the selected Proposer(s) subject to successful negotiation of any negotiable provisions.

## 4.2 INTENT TO AWARD PROTEST

### 4.2.1 Protest Submission

An Affected Offeror shall have seven calendar days from the date of the intent to award notice to file a Written protest.

A Proposer is an Affected Offeror only if the Proposer would be eligible for Contract award in the event the protest was successful and is protesting for one or more of the following reasons as specified in ORS 279B.410:

- All higher ranked Proposals are non-Responsive.
- Agency has failed to conduct an evaluation of Proposals in accordance with the criteria or process described in the RFP.
- Agency abused its discretion in rejecting the protestor's Proposal as non-Responsive
- Agency's evaluation of Proposals or determination of award otherwise violates ORS Chapter 279B or ORS Chapter 279A.

If Agency receives only one Proposal, Agency may dispense with the intent to award protest period and proceed with Contract Negotiations and award.

**4.2.1.1** Protests must:

- Be delivered to the SPC via email, facsimile or hard copy.
- Reference the RFP number.
- Identify prospective Proposer's name and contact information.
- Be signed by an authorized representative.
- Specify the grounds for the protest.
- Be received within seven calendar days of the intent to award notice

### 4.2.2 Response to Protest

Agency will address all timely submitted protests within a reasonable time and will issue a Written decision to the respective Proposer. Protests that do not include the required information may not be considered by Agency.

## 4.3 APPARENT SUCCESSFUL PROPOSER SUBMISSION REQUIREMENTS

### 4.3.1 Insurance

Prior to execution of the Contract, the apparent successful Proposer shall secure and demonstrate to Agency proof of insurance coverage meeting the requirements identified in the RFP or as otherwise negotiated.

Failure to demonstrate coverage may result in Agency terminating Negotiations and commencing Negotiations with the next highest ranking Proposer. Proposer is encouraged to consult its insurance agent about the insurance requirements contained in Insurance Requirements (Exhibit C of Attachment A) prior to Proposal submission.

### 4.3.2 Taxpayer Identification Number

The apparent successful Proposer shall provide its Taxpayer Identification Number (TIN) and backup withholding status on a completed W-9 form if either of the following applies:

- When requested by Agency (normally in an intent to award notice), or
- When the backup withholding status or any other information of Proposer has changed since the last submitted W-9 form, if any.

Agency will not make any payment until Agency has a properly completed W-9.

### 4.3.3 Tax Affidavit

Prior to execution of the Contract, the apparent successful Proposer shall complete and submit the Tax Affidavit (Attachment E) to demonstrate compliance with Oregon Tax Laws.

Failure to demonstrate compliance may result in a finding of non-responsibility.

### 4.3.4 Business Registry

If selected for award, Proposer shall be duly authorized by the State of Oregon to transact business in the State of Oregon before executing the Contract. The selected Proposer shall submit a current Oregon Secretary of State business registry number, or an explanation if not applicable.

All Corporations and other business entities (domestic and foreign) must have a Registered Agent in Oregon. See requirements and exceptions regarding Registered Agents. For more information, see Oregon Business Guide, How to Start a Business in Oregon and Laws and Rules. The titles in this subsection are available at the following Internet site: http://www.filinginoregon.com/index.htm.

## 4.4 CONTRACT NEGOTIATION

### 4.4.1 Negotiation

By submitting a Proposal, Proposer agrees to comply with the requirements of the RFP, including the terms and conditions of the Sample Contract (Attachment A), with the exception of those terms reserved for negotiation. Proposer shall review the attached Sample Contract and note exceptions. Unless Proposer notes exceptions in its Proposal, the State intends to enter into a Contract with the successful Proposer substantially in the form set forth in Sample Contract (Attachment A). It may be possible to negotiate some provisions of the final Contract; however, many provisions cannot be changed. Proposer is cautioned that the State of Oregon believes modifications to the standard provisions constitute increased risk and increased cost to the State. Therefore, Agency will consider the scope of requested exceptions in the evaluation of Proposals.

Any Proposal that is conditioned upon Agency's acceptance of any other terms and conditions may be rejected. Any subsequent negotiated changes are subject to prior approval of the Oregon Department of Justice.

All items, except those listed below, may be negotiated between Agency and the apparent successful Proposer in compliance with Oregon State laws:

- Choice of law
- Choice of venue
- Constitutional requirements
- Centers for Medicare and Medicaid Services requirements
- Indian Healthcare Improvement Act or Indian Self-determination Act provisions
- American Recovery and Reinvestment Act or Affordable Care Act provisions.

In the event that the parties have not reached mutually agreeable terms within 10 business days, Agency may terminate Negotiations and commence Negotiations with the next highest ranking Proposer.

# SECTION 5: ADDITIONAL INFORMATION

## 5.1 OMWESB PARTICIPATION

Pursuant to Oregon Revised Statute (ORS) Chapter 200, and as a matter of commitment, Agency encourages the participation of minority, women, and emerging small business enterprises in all contracting opportunities. Agency also encourages joint ventures or subcontracting with minority, women, and emerging small business enterprises. For more information please visit http://www.oregon.gov/gov/MWESB/Pages/index.aspx

If the Contract results in subcontracting opportunities, the successful Proposer may be required to submit a completed OMWESB Outreach Plan (Attachment H) prior to execution.

## 5.2 GOVERNING LAWS AND REGULATIONS

This RFP is governed by the laws of the State of Oregon. Venue for any administrative or judicial action relating to this RFP, evaluation and award is the Circuit Court of Marion County for the State of Oregon; provided, however, if a proceeding must be brought in a federal forum, then it must be brought and conducted solely and exclusively within the United States District Court for the District of Oregon. In no event shall this section be construed as a waiver by the State of Oregon of any form of defense or immunity, whether sovereign immunity, governmental immunity, immunity based on the eleventh amendment to the Constitution of the United States or otherwise, to or from any Claim or from the jurisdiction of any court.

## 5.3 OWNERSHIP/PERMISSION TO USE MATERIALS

All Proposals submitted in response to this RFP become the Property of Agency. By submitting a Proposal in response to this RFP, Proposer grants the State a non-exclusive, perpetual, irrevocable, royalty-free license for the rights to copy, distribute, display, prepare derivative works of and transmit the Proposal solely for the purpose of evaluating the Proposal, negotiating an Agreement, if awarded to Proposer, or as otherwise needed to administer the RFP process, and to fulfill obligations under Oregon Public Records Law (ORS 192.410 through 192.505). Proposals, including supporting materials, will not be returned to Proposer unless the Proposal is submitted late.

## 5.4 CANCELLATION OF RFP; REJECTION OF PROPOSALS; NO DAMAGES.

Pursuant to ORS 279B.100, Agency may reject any or all Proposals in-whole or in-part, or may cancel this RFP at any time when the rejection or cancellation is in the best interest of the State or Agency, as determined by Agency. Neither the State nor Agency is liable to any Proposer for any loss or expense caused by or resulting from the delay, suspension, or cancellation of the RFP, award, or rejection of any Proposal.

### 5.5 COST OF SUBMITTING A PROPOSAL

Proposer shall pay all the costs in submitting its Proposal, including, but not limited to, the costs to prepare and submit the Proposal, costs of samples and other supporting materials, costs to participate in demonstrations, or costs associated with protests.

### 5.6 STATEWIDE E-WASTE/RECOVERY POLICY

If applicable, Proposer shall include information in its Proposal that demonstrates compliance with the Statewide E-Waste/Recover Policy effective July 1, 2012.

### 5.7 RECYCLABLE PRODUCTS

Proposer shall use recyclable products to the maximum extent economically feasible in the performance of the Services or Work set forth in this document and the subsequent Contract. (ORS 279B.025)

## SECTION 6: LIST OF ATTACHMENTS

| | |
|---|---|
| ATTACHMENT A | SAMPLE CONTRACT |
| ATTACHMENT B | AFFIDAVIT OF TRADE SECRET |
| ATTACHMENT C | PROPOSER CERTIFICATION SHEET |
| ATTACHMENT D | PROPOSER INFORMATION SHEET |
| ATTACHMENT E | TAX AFFIDAVIT |
| ATTACHMENT F | RESERVED |
| ATTACHMENT G | COST PROPOSAL FORM |
| ATTACHMENT H | OMWESB OUTREACH PLAN |